NAME

Last | First | Middle

Age | Ethnicity | Gender

Date of Birth | Marital Status: Never Married | Referred By (How Did You Find Us?)

Occupation | Education Level | Company/School

ADDRESS Street | City | State | Zip

PHONE ○ Home ○ Cell ○ Work **(Check Preferred Phone)**

E-MAIL (to send receipts)

EMERGENCY CONTACT Name | Relationship

○ Phone (Home) ○ Phone (Cell) ○ Phone (Work) **(Check Preferred Phone)**

PREFERRED PHARMACY | Location (Cross Streets and Zip) | Phone

CURRENT THERAPIST | Phone | Fax

PRIMARY CARE PHYSICIAN | Phone | Fax

SPECIALISTS (CARDIOLOGIST, OB/GYN, ETC.) | Phone | Fax

CONDITIONS OF SERVICE

OFFICE HOURS – The office is open by appointment only. We are closed on all major holidays. Office hours are Monday-Thursday from 9:00 AM-5:00 PM, and Fridays from 10:00 AM-2:00 PM. The phones are off during the lunch break from 12:30 PM-1:30 PM Mondays-Thursdays.

CANCELLATION POLICY & MISSED APPOINTMENTS – As a courtesy, we provide a confirmation call prior to your appointment. Please note, you are still responsible for notifying the office **AT LEAST 24-BUSINESS HOURS IN ADVANCE (M-F, excluding holidays)** if you need to change or cancel your appointment. Otherwise, you will be responsible for the **full fee** of the session.

EMERGENCIES – We do not offer an "on-call" physician service at any time. If there is any question as to the safety of yourself or a loved one, call 911 or go to your nearest Emergency Room.

PRESCRIPTION REFILLS – Please call our office **AT LEAST ONE WEEK** prior to the last day of your prescription. Controlled Substances will be sent electronically to your pharmacy. Please allow 1-2 business days to process your request.

MEDICATION MANAGEMENT – In order to meet the minimum standard of care (provided that patient is stable and there are no changes to current medication regimen), the frequency of follow-up appointments must be no less than: two 30-minute visits per year, or three 15-minute visits per year. In order to re-establish care, a 45-minute appointment (minimum) may be required.

CONTACTING OUR OFFICE – Routine questions will be answered by our Front Desk staff during normal business hours. For more extensive questions that require contact with your physician (including other doctors), you will be required to schedule a 15-minute phone appointment.

CONTACTING OUTSIDE PROVIDERS – When contacting a provider outside the office (school officials, therapists, etc.) you will be charged on a prorated basis for any communication lasting longer than 5 minutes.

SOCIAL MEDIA/EMAIL POLICY – Please do not email us content related to your treatment or therapy sessions, as email is not completely secure or confidential. Engaging in social media content published by WPPA does not constitute medical or psychological care and does not guarantee anonymity as a patient.

SCHOOL REPORTS & DISABILITY DOCUMENTATION – We do not bill for routine school/work excusal forms to attend your appointment, however, if you require more extensive documentation of disability, you will be billed for the amount of time it takes your physician to complete the report.

LEGAL DOCUMENTATION, TESTIMONY & SERVICES – In the event that legal testimony, documentation or consultation is required for any reason (with or without a subpoena), you are financially responsible for the amount of time needed to complete the service, including travel if needed. The rate for these services is $250 per hour billable in 15-minute increments. Note that Westlake Psych does not provide forensic psychological services, such as making recommendations in child custody cases, as this is beyond the scope of her training. If such services are requested or recommended, a referral will be provided.

DISCONTINUATION OF CARE – While we do not expect this to be the case, there are rare occasions when it is necessary to terminate the physician-patient relationship. Discontinuation of treatment may occur at any time and may be initiated by either the patient or the doctor. Reasons for termination by the physician may include patient non-compliance with treatment, missed appointments, and maltreatment or threats towards the physician or office staff. By signing this form, you acknowledge that if discontinuation of treatment occurs you will receive verbal and/or written notice, and your file will be closed.

PAYMENT POLICY & INSURANCE – Payment is due in full at the time of the scheduled appointment, and we will charge the card on file the morning of the appointment. We accept cash, check or credit card. Our office does not file directly with insurance, however, upon payment, we will e-mail you the documentation that you may send to your insurance for reimbursement. Regardless of your preferred method of payment, we **require** you to provide a credit card number in the space below:

☐ VISA ☐ Discover ☐ MasterCard

Name as it Appears on Card

Billing Zip Code

Card Number

Expiration

Security Code (required)

*By signing (or typing) my name below, I agree to the **Conditions of Service** explained above, accept full financial responsibility and authorize Westlake Psychiatry, P.A. (D/B/A "Westlake Psychiatry") to bill my credit card for services as described above unless I specify an alternative payment method in advance. Additionally, I am providing: 1) Ongoing consent to communicate with individuals that I have listed in order to facilitate the treatment of my dependent or myself, 2) My informed consent to accept sole-responsibility for the risks and benefits associated with the medical treatment of my dependent or myself, including the actions, inactions or unintentional errors of individuals at Westlake Psychiatry, P.A. (D/B/A "Westlake Psychiatry"), including the entity as a whole.*

SIGNATURE: _____ **DATE:** _____

Today's Date: _____

Describe the reason for today's visit, and the symptoms causing the most difficulty:

When did these symptoms start? How have they changed over time?

List any significant life changes, stressors or events that have occurred in recent years (include dates):

Please List **Previous Mental Health Providers** Below (beginning with the very first treatment)

NAME OF PSYCHIATRIST, COUNSELOR, OR FACILITY	APPROXIMATE DATES	AGE	DIAGNOSIS

LIST CURRENT MEDICATIONS (include herbals, supplements, and all medical prescriptions)

NAME, DOSAGE, & FREQUENCY	START DATE	PRESCRIBED BY	RESPONSES & SIDE-EFFECTS

DRUG ALLERGIES (Include Reaction): _____

PREVIOUS MEDICATION TRIALS (List All Previous Medications and Include Response & Length of Trial)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

HAVE YOU USED ANY OF THE FOLLOWING ?

Caffeine? ☐ Yes ☐ No (Beverage, Amount & Frequency): _____

Alcohol? ☐ Yes ☐ No (Beverage, Amount & Frequency): _____

Tobacco? ☐ Yes ☐ No (Amount & Frequency) _____

Marijuana? ☐ Yes ☐ No (Amount & Frequency) _____

Other Drugs? ☐ Yes ☐ No (Include even if Infrequent) _____

FAMILY NEUROPSYCHIATRIC HISTORY (Include Any Successful Treatment Information if Pertinent)

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

☐ Anemia	☐ Urinary Problems	☐ Menstrual Cramping	☐ Arthritis
☐ Seasonal Allergies	☐ Kidney Problems	☐ Autoimmune Illness	☐ Mononucleosis
☐ Asthma	☐ Constipation	☐ Stomach Upset	☐ Drug Allergies:
☐ Hypertension	☐ Liver Disease	☐ Epilepsy	☐ Infectious Disease
☐ Heart Problems	☐ Diabetes	☐ Headaches	☐ Cancer
☐ Chronic Pain	☐ Thyroid Disease	☐ Glaucoma	☐ Other (Describe Below)

Other Illnesses, Injuries or Surgeries: _____

FAMILY MEDICAL HISTORY (Include Extended Family) _____

_____

INDIVIDUALS LIVING AT PATIENT'S RESIDENCE (include pets)

NAME (INCLUDE ANY PETS)	RELATIONSHIP	AGE

Mother's Name _____ Age _____ Occupation _____

Father's Name _____ Age _____ Occupation _____

Important Individuals Not Living in the Home: _____

List Important Activities, Hobbies and Interests: _____

Please List Important Strengths and Weakness (Academic, Socially, Work-Related, etc.):

_____

Do You Have Any Goals for Treatment?

1) _____

2) _____

3) _____

Other: _____